Request/Authorization to Release Confidential Records and Information

I hereby authorize:

Person or facility: _____ to release/obtain information about

_____ (your name) , born on _____ (your DOB).

To/From:

Person or Facility _____

Address:_____ Phone:_____

for the following purpose(s):

- ☐ Continuing treatment, care, and/or mental health evaluation ☐ Treatment Planning
- ☐ Insurance Coverage ☐ Emergency ☐ Financial
- ☐ Other: _____

In the boxes below, the information to be disclosed is marked by an X:

- ☐ Intake and/or discharge summaries ☐ Summary of treatment ☐ Progress notes
- ☐ Information needed for my insurance coverage
- ☐ Phone contact regarding any relevant history or diagnoses and other similar information that can assist with my receiving treatment or being evaluated or referred elsewhere:
- ☐ Other: _____

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____

Signature of client Printed name Date

_____

Signature of parent/guardian/representative Printed name Relationship Date